



PATIENT REFERRAL/APPOINTMENT FORM

Fax Completed Form to 912/352-9031

The following information is required with your faxed request:

- ✓ Insurance referral (if required)
- ✓ Insurance cards (Front & Back)
- ✓ Medical Records (to include office notes, operative reports, laboratory, radiology and pathology reports)
- ✓ If being seen for elevated PSA, please include last 5 years of results

Our Process:

1. We will make three (3) attempts to contact the patient. If unsuccessful, we will notify the patient via a letter and the referring provider will receive a fax copy of that letter.
2. Once an appointment has been made, we will send you a confirmation via fax sharing the date and time of the appointment. We will not fax hospitals back.

PHYSICIAN REQUESTED/PREFERRED:

- BOYD CHENG COX RUTH ANN MAZO ANDREW MICHIGAN
 SHOOK SWAVELY **FIRST AVAILABLE**

PREFERRED LOCATION: SAVANNAH

CHECK ONE:

- URGENT REFERRAL** (1-2 days)
 ASAP Appointments (3-7 days)
 Routine Referral - first available appointment
 Referring Physician has already spoken with one of our physicians regarding this patient

REASON FOR REFERRAL/DIAGNOSIS (leaving blank will cause delays in scheduling your patient)

WAS PATIENT SEEN IN THE E.R.? YES NO If Yes, what hospital? _____

PATIENT'S LAST NAME _____ **FIRST** _____ **MIDDLE** _____
DOB: ____/____/____ MALE FEMALE SOCIAL SECURITY _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

DAYTIME PHONE _____ WORK PHONE _____ CELL _____

PATIENT'S EMAIL ADDRESS _____

PRIMARY INSURANCE INFORMATION

INSURED'S NAME _____ RELATION TO PATIENT _____

COMPANY NAME _____ POLICY # _____

GROUP # _____ REFERRAL NEEDED? YES NO REF # _____

REFERRING MD NAME _____ NPI# _____ PHONE _____

NAME OF CALLER _____ PHONE _____ FAX _____

FOR UROLOGICAL ASSOCIATES OFFICE TO COMPLETE:

PATIENT HAS APPOINTMENT WITH DR. _____ **ON** _____ **TIME** _____ OAM OPM

Appointment made by _____ **on this date** _____

Thank you for your referral. Should you have any questions, call us at our MAIN PHONE 912/790-4000

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